**DIABETES SELF-MANAGEMENT EDUCATION ACCREDITATION PROGRAM**

**REGISTRATION FORM**

Today’s Date: \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / 2 0 1 \_\_

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Name of the individual completing the form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SITE INFORMATION:**

Name of Participating Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person of Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Email

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:

Type of Health Care Organization:

□ FQHC

□ Hospital

□ Pharmacy

□ Area Agency on Aging

□ Other (Please Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_

Does your organization:

1. Have Medicare Billing Capacity? Yes □ No □

If no, are you in partnership with an organization who is? Yes □ No □

1. Have a Pharmacist, RD, RN or CDE on staff for this program? Yes □ No □
2. Have instructional staffing in place for this program? Yes □ No □
3. Currently provide diabetes self-management? Yes □ No □